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POPULI

Vol. 20, No. 3 The UNFPA Magazine March 1993

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Cover: Jane Schreibman

FEATURES

Cambodia's Women: Shouldering the Burden **8**
by Pat Orvis
As long-suffering Cambodia struggles to rescue peace and stability from decades of unremitting violence, its social fabric is being held together by its women. Two-thirds of the country's adults are women; they are the majority of the workforce, and the overwhelming majority of manual and unskilled labourers. Many thousands of them are young war widows with an average of six children. The fulfilment of their basic needs, their hopes for peace, and their aspiration to a just position in Cambodian society and polity are tied to elections to be held by the end of May.

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More than mothers **13**
Many aspects of women's health remain neglected. Over the past few decades, our understanding of women's health has been driven by a focus on fertility regulation. While this has had its benefits, it limits our understanding of women's health and lives to the reproductive years and reproductive system. It's time we saw women as more than baskets of eggs. Women's health experts Marge Koblinsky, Oona Campbell, and Siobán Harlow suggest how we might do this.

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READEX
FICHE

European Policy

North and South "are increasingly interdependent now in matters such as the environment, population, and AIDS," according to the latest European Community (EC) policy paper on development cooperation to the year 2000. Henceforth, therefore, EC policy will aim to "restore the economic bases of growth, ensuring that this is compatible with environmental demands" by, among other things, "paying constant attention to the long-term conditions of lasting development—i.e. family planning and education policies to get demographic growth under control."

The EC will also "encourage the consolidation of democracy in the developing countries, within the framework of a return to political stability," and help "make these countries a proper part of the world economy."

Women in Development

Japan is keen on stepping up efforts to improve the status of women in developing countries, according to the foreign ministry. Under the government's first-ever Women in Development (WID) policy, projects encouraging women's direct participation and aiming to improve women's livelihoods must be favoured in disbursements of Official Development Assistance (ODA). Japan is the world's largest donor, with a government allocation of more than a trillion yen, or about US$8 billion, for ODA in 1993.

Foreign ministry spokesperson Keiko Ishihara is quoted by Inter Press Service (IPS) as saying that, as of last month, no budget had been allocated to bilateral aid for WID projects. "Our projects are part of the big projects in the overall ODA budget," she said. "For example, we hope that by building a dam, agricultural production will improve and thus benefit women." Also, aid to women would be channeled through the United Nations Development Fund for Women, UNFPA, and various non-governmental organizations.

The WID policy has got the attention of women's advocates, such as Yayoi Matsui of the Tokyo-based Asian Women's Association (AWA), who say conventional ODA-funded projects have harmed rather than helped women. AWA, which works with other women's groups in the region, recently issued a report citing examples of projects that have affected women adversely. "We are saying nothing new," Matsui told IPS. "The report is a way of arousing interest in the topic of women in development," a topic she fears is still "only a fashionable phrase."

Jamaica Survey

Jamaica's 1993 Contraceptive Prevalence Survey will seek to gauge males' perceptions regarding, attitudes toward, and practice of contraception. This is the first time males have been specifically targeted in the history of the Survey, which was first conducted in 1974, UNFPA Director for the Caribbean K.V.R. Moorthy reports from Kingston. "This is considered important in view of the generally low levels of male involvement" in family planning in the Caribbean, he says. Minister of Health Easton Douglas launched the Survey on 9 February. Preliminary findings are expected by September, and the final report is likely to be published early next year.

Previous Surveys were conducted in 1974, 1979, 1983, and 1989, when contraceptive prevalence was estimated at 55 per cent among women aged 15-49 years who were in relationships. Nearly seven in ten women in the reproductive age group were reportedly in relationships at the time.

Contraceptives for Carnival

The Family Planning Association of Trinidad and Tobago (FPATT) marked carnival this year by offering free condoms and contraceptive services in a bid to prevent an annual surge in unwanted pregnancies. At a 4 February press conference in Port of Spain, FPATT President Emile Elias said contraceptives would be made available at no cost to people aged 15-25 years. He said a study released recently showed that births increased by 20 per cent nine months after carnival celebrations, and that spontaneous abortions rose by 17 per cent in that period. Over 84 per cent of the unplanned pregnancies involved 15-25-year-olds.

Carnival is officially celebrated on the two days preceding Ash Wednesday, which this year fell on 24 February. FPATT officials say the official celebration marks the end of a festive season that begins in late December. In previous years, FPATT promoted condom use under such slogans as "Be wise, Condomize."

Military Condoms

Prophylaxis by condom took on an added dimension during the Gulf War, when a British company reportedly was awarded a special contract to supply allied troops with 500,000 camouflaged military condoms. Sources quoted in press reports said the sand-coloured condoms were intended exclusively for military use—to stop sand getting into rifle barrels.

Brazilian Fertility

Fertility rates in Brazil have plummeted over the past decade, according to the government's recently-released 1991 census report. Observers attribute this to prolonged economic stagnation, which forced many women to shore up family incomes by seeking paid work, and to sterilization, which became the most common means of preventing pregnancy.

"We are seeing an ongoing phenomenon of consistently decreasing fertility rates

for women in Brazil," Valeria de Mota Leite of the government statistical institute IBGE told the Reuters news agency, adding: "The decrease is accelerating." On average, Brazilian women had 4.36 children each in 1980. By 1990, the average fell to 2.9. The average annual population growth rate fell from 2.48 per cent during the 1970s, to 1.93 per cent in 1980-91.

Vasectomy Reversals

As divorce and remarriage become more common, and as surgical technology and methods improve, increasing numbers of men in Canada are opting to reverse their vasectomies, according to doctors quoted in the local press. Some, having had reversals in recent years, are opting for second vasectomies. Most men seeking reversals are aged 45-55 years, doctors say.

Whereas vasectomies are performed with a local anaesthetic in minutes, reversals require general anaesthesia and take an hour or two. Doctors warn the chances of success diminish with the passage of time between vasectomy and reversal. Female partners should be examined to assure they are fertile and ovulating correctly, they add.

Some men are finding that although their vasectomies were covered by health insurance, they are having to foot the bill for reversal.

Health Education Conference

The Third European Conference on Health Education is scheduled for 24-26 May in Amsterdam, Netherlands. It's theme will be "Health Education and Mass Media: How to communicate effectively." For more information, contact: Ms. Marianne Smit, Dutch Centre for Health Education and Health Promotion, P.O. Box 5104, 3502 JC Utrecht, Netherlands. Fax: (31) 30-964082.

ICPD Update

The latest on the lead-up to the International Conference on Population and Development, 5-13 September 1994, Cairo, Egypt.

NGO Accreditation:

The ICPD Secretariat is inviting non-governmental organizations (NGOs) wishing to attend the Cairo Conference and the remaining two sessions of the Preparatory Committee to apply for accreditation by Friday, 16 April 1993. Under the terms of a United Nations Economic and Social Council (ECOSOC) resolution, NGOs with consultative status with ECOSOC will be accredited for participation. Others should apply, and will be asked to submit documents establishing their bona fides and confirming their interest in the goals and objectives of the Conference. For details of application requirements, see the upcoming issue of *ICPD 94*, the official Conference newsletter, or contact: ICPD Secretariat, NGO Accreditation Unit, c/o UNFPA, 220 East 42nd Street, 17th floor, New York, NY 10017, USA.

Job Vacancy:

The ICPD NGO (non-governmental organization) Planning Committee is looking for an Administrator to work on NGO representation at relevant events and a global information programme. Candidates must have international NGO experience and be familiar with the UN system; they must be available to start immediately and be eligible to work in the United States. Contact: NGO Planning Committee for ICPD, 777 United Nations Plaza, Suite 7-C, New York, NY 10017, USA. Telephone: (212) 687-3366. Fax: (212) 661-4188.

Upcoming Events:

- 23-26 March, Geneva, Switzerland: 1993 European Population Conference, jointly organized by the Economic Commission for Europe, the Council of Europe, and UNFPA.

- 4-8 April, Amman, Jordan: Arab Population Conference, jointly organized by the Economic and Social Commission for Western Asia, the League of Arab States, and UNFPA.

- 29 April-4 May, Mexico City, Mexico: Regional Population and Development Conference for Latin America and the Caribbean, jointly organized by the Economic Commission for Latin America and the Caribbean and UNFPA.

- 10-21 May, UN Headquarters, New York: Second meeting of the Preparatory Committee for the International Conference on Population and Development 1994.

Vasectomy:

Avoiding panic over prostate cancer

Few things scare men more than the possibility that vasectomies, long regarded by health experts as one of the safest contraceptive methods, might pose a health risk. That truism was underscored last month, when physicians and family planning officials tried to pre-empt possible overreaction to a study linking vasectomies to prostate cancer.

The study, published in two parts in the 17 February issue of the *Journal of the American Medical Association*, demonstrates an increased incidence of prostate cancer among men who have had vasectomies, with one finding linking the surgical procedure to a 66-per cent elevated risk 15-20 years after the surgery. Family planning experts quickly asked for further examination of the results to determine whether they were flawed by factors such as selection bias and chance.

The study's authors admit they were unable to prove a causal relationship between vasectomy and prostate cancer. Although two previous studies found no linkage, the calibre of the latest *Journal* study, headed by Edward Giovannucci of Brigham and Women's Hospital in Boston, drew widespread attention in the medical community.

UNFPA/Lily Solmssen

Vasectomy counselling: Relax.

"If vasectomy is a risk factor for prostate cancer, people need to know and informed choices need to be made," say doctors Stuart Howards and Herbert Peterson in a *Journal* editorial accompanying the study by Dr. Giovannucci and his colleagues. "By contrast, if associations are spurious but believed to be real, the popularity of a highly effective contraceptive will be reduced, opportunities to reduce unintended pregnancies will be lost, and maternal and infant mortality and morbidity will increase."

Worries about prostate cancer in the industrial world already are quite high; approximately one in 11 males in the US will develop prostate cancer for reasons that continue to confound health professionals. But the US-based Association for Voluntary Surgical Contraception (AVSC) warns that while the findings should not be ignored, "neither should the public nor medical professionals overreact to this new information."

Vasectomy is still "no different from any of the other contraceptive methods, which all have their risks," says AVSC Vice President and Medical Director Amy Pollack. Indeed, the World Health Organization concluded as much in 1991, when a group of experts it convened reported after extensive study "that on the basis of existing biological and epidemiological evidence, any causal relationship between vasectomy and the risk of prostate or testicular cancer was unlikely and no changes in family planning policies concerning vasectomy are justified."

The Giovannucci study does not threaten that conclusion. The authors conjecture that the reduction in prostatic secretions following a vasectomy could expose the gland to carcinogenic factors. But experts at AVSC and elsewhere point out that most models of cancer development suggest that a decrease in such secretions actually would be expected to reduce cancer risks. What causes prostate cancer remains a mystery, and vasectomy remains as unconnected to any increase in mortality as before, experts say.

Facts are one thing. Perception, however, has long been what counts in affecting the popularity of vasectomy. In the 1970s, another US study found an increased risk of atherosclerosis—a cardiovascular condition like arteriosclerosis, in which arteries harden—in vasectomized monkeys. After a decade of examination, the monkey study was disproved, but the damage had been done: vasectomies in the US decreased sharply.

Family Health International (FHI), which has sought to foster greater awareness among men in the developing world about their need to accept family planning responsibility, views

the Giovannucci findings with both caution and some concern over how perceptions in the North could be translated into policy in developing countries.

"Even a man who has had a vasectomy still has a very low risk of cancer," says FHI President Theodore King. Even if the correlation found by Giovannucci and his colleagues hold up in subsequent studies, King notes, the risks associated with vasectomy still would be less than those that child-bearing women face from pregnancy. In India alone, health risks linked to pregnancy and child-bearing are estimated to be 400 times greater than those linked to any form of contraception.

That disparity may mean little to men already suspicious of undergoing surgical contraception, however. Family planning programme staff in numerous countries report that men are wary of undergoing a procedure they mistakenly equate with castration. The mistaken fear that vasectomy will render them unable to ejaculate seems especially persistent, despite evidence to the contrary. As one US family planning advocate puts it: "The whole burden of birth and child care falls on women. All forms of birth control have risks and women are willing to bear the cost. But when it comes to men, the situation is different." She adds that the degree of concern over the possibility of a prostate cancer-vasectomy linkage is strong precisely because "it's happening to men and not to women."

For now, experts advise further research, the continuation of existing vasectomy policies, and annual examinations for prostate cancer among men who have undergone vasectomies and for all men aged 50-70 years. The American Urological Association urges men who have had vasectomies not to have them reversed to try to prevent cancer.

-Farhan Haq

For a quick comparison of male and female sterilization, turn to Notebook, page 20.

UN Population Award:

And the winners are

Veteran Ghanaian researcher and family planning advocate Fred Sai and the Mainichi Shimbun Population Problems Research Council of Japan will share this year's United Nations Population Award.

The laureates will receive their awards—a diploma, a gold medal, and a monetary prize—at a ceremony later this year. They were chosen from among 16 nominations by the Committee of the United Nations Population Award last month.

Dr. Sai is noted for his contributions to research on nutrition, community welfare, and family planning. He served as chair of the Main Committee of the 1984 International Population Conference and chaired the 1987 World Health Organization-United Nations Children's Fund Meeting on Infant and Young Child Feeding, the findings of which are credited with providing the impetus for the International Code of Marketing for Breast-Milk Substitutes. A former population adviser to the World Bank, he was elected president of the International Planned Parenthood Federation in 1989, and re-elected last year.

Mainichi Shimbun Population Problems Research Council is credited with creating awareness of population issues through *Mainichi Shimbun*, the newspaper that created the Council in 1949, and by continually publishing studies, books, and articles on population. Every two years since 1950, it has conducted a national opinion survey of family planning believed to be the world's longest-running and largest survey of its type, in sample size. In the course of time, it broadened its domestic focus to include international population problems, and is credited with helping create support in Japan for international population programmes.

The award committee is made up of representatives from 10 UN member states elected to three-year terms by the Economic and Social Council. The current members are: Belarus, Burundi, Cameroon, Ecuador, El Salvador, India, Japan, Mexico, Netherlands, and Rwanda. UN Secretary-General Boutros Boutros-Ghali and UNFPA Executive Director Nafis Sadik serve as ex-officio members. There are five honorary advisors. Nominations are made by member-state governments, inter- and non-governmental organizations doing population-related work, university professors or heads of population-related institutions, and past laureates.

AIDS Prevention:

Adding to the arsenal?

It may look like a jellyfish or an oddly-shaped balloon, but researchers and health officials are looking

UNICEF/Marcus Maleri

Men are ten times more likely to transmit HIV to women than vice versa, yet women have to rely on men to use condoms. Experts hope the female condom will enable women—most urgently, sex workers—to protect themselves.

to the female condom as a potentially significant weapon in the fight against AIDS.

The female condom's manufacturers say its main purpose is to prevent unplanned pregnancies. But in countries struggling to contain the spread of AIDS, the device's infection-preventing potential is receiving more attention than its contraceptive effect. Studies are still under way, but experts say that if the female condom proves effective in preventing infection with the human immunodeficiency virus (HIV), it will be the first such device to be under women's control.

Femidom®, described by its manufacturers as "a loose-fitting, prelubricated polyurethane sheath," went on the market in Austria, Britain, and Switzerland last year, and in the Netherlands in January. Its counterpart in the United States, Reality®, is awaiting approval by the Food and Drug Administration.

The Thai Ministry of Public Health and the World Health Organization (WHO) have been conducting studies among sex workers, to see how acceptable Femidom would be. As many as seven in ten sex workers in Thailand carry HIV, according to WHO estimates. The purpose of the study is to give female sex workers whose clients refuse to wear condoms the option of using Femidom, which can be inserted minutes or hours before intercourse. If the response to the device is positive, the Thai government will allow the import and production of female condoms in the country. Officials point out that this would be in addition to existing efforts to promote male condom use and to stamp out forced and child prostitution; the idea is to empower voluntary sex workers to protect themselves and their clients.

The Thai study has the support of Chartex International PLC, Femidom's British manufacturer, although the company prefers that such work remain low-key. "It is a deliberate part of our marketing to steer clear of the AIDS arena because if Femidom is marketed as an AIDS-prevention device, people who feel they are not at risk won't use it," says Leigh Taylor, Chartex's marketing manager.

The company's American licensee, Wisconsin Pharmacal, has incorporated AIDS-prevention in its marketing strategy, however. Last September, the company issued a press release hailing the device as "the first new product marketed to help prevent the spread of AIDS since the epidemic began more than 10 years ago that is under the woman's control."

Laboratory studies have shown that "certain disease-causing organisms, including HIV, do not penetrate the plastic membrane from which Femidom is made," according to the London-based Margaret Pyke Centre, one of the largest specialized family planning clinics in the world. The centre adds, however, that more research is needed to find out how well Femidom performs in this respect in actual use.

Researchers at the Centre note a strong demand for the product. In a report in the *British Journal of Family Planning*, they said: "The concept of a condom for use by the female appears to be of considerable interest to women and to health care professionals alike, as demonstrated

by the large number of inquiries received by the investigators."

As of January, some 30,000 female condoms had been used in studies in 17 countries involving 1,500 couples. Participants have reported advantages as well as drawbacks.The main advantage is that women who want to protect themselves against sexually transmitted diseases no longer have to rely on their partner's willingness to use a condom. Breakage is rare, and there is "less loss of sensitivity for the man, compared with the male condom," according to the Pyke Centre researchers.

There are complaints, however, mostly to do with the device's appearance, difficulty with inserting it, "and the need to guard against the entire Femidom being pushed in or inadvertent penetration outside the device," the researchers say. Some users also say it is noisy.

The female condom is a polyurethane sheath with two flexible rings. One ring, which lies inside the sheath at its closed end, serves as an insertion device and holds it in place so that it fits over the cervix much like a diaphragm. The other ring forms the external edge of the sheath and remains outside the vagina.

-Alecia McKenzie/IPS

Eastern Europe:

Shifting policies

Albania, Hungary, and now Poland are the most recent Eastern European countries to change their laws on abortion and family planning.

Polish President Lech Walesa last month signed legislation imposing major new restrictions on abortion. The legislation allows abortion when there is a serious threat to the life or health of the pregnant woman, if the pregnancy is the result of rape or incest, or if prenatal tests show the foetus to be seriously and irreversibly damaged. All abortions must be performed in hospitals. Physicians who perform illegal abortions will be subject to up to two years' imprisonment, although women who perform abortions upon themselves are exempt from such punishment.

The Polish legislation obligates the government to provide "access to family planning methods" as a means of reducing demand for abortion. It requires schools to allow pregnant pupils maternal leave and to introduce classes on sexual behaviour, and specifically allows prenatal testing in cases where such testing will not increase the risk of miscarriage.

The legislation, which was approved by both houses of parliament in January, replaces laws dating from 1956 that allowed abortions, in effect, on request during the first twelve weeks of pregnancy under the indication of "difficult living conditions." Once approved, it was submitted to Walesa, who had thirty days to sign it into law.

In Hungary, parliament adopted a new abortion law last December. Hungary's Constitutional Court had ruled in late 1991 that the existing two-decades-old regulations allowing abortion, in effect, on request were unconstitutional because they were issued by government ministers rather than enacted by parliament. The Court gave legislators a year to rectify the situation.

Under the new law, abortions will be allowed during the first twelve weeks of pregnancy if there is a threat to health; if it appears that the child will be born with a serious handicap; if the pregnancy results from a criminal act such as rape or incest; or if the pregnant woman is suffering from a "serious crisis." Abortions must be approved by a representative of the Family Protection Office who will counsel the pregnant woman on contraception and alternatives to abortion. Women whose abortions are approved will have to wait three days for the procedure. Except for the counselling provision, the new law is essentially similar to the old regulations. It is expected that its enactment will make little difference in the number of abortions performed in Hungary.

Albania's Council of Ministers last May reversed decades of pronatalist policy that had restricted contraceptives and outlawed abortion. At the urging of the Ministry of Health, they issued a Decision on the "Approval of activities concerning family planning in Albania."

The Decision designates family planning as a "basic human right from which all citizens should be able to benefit of their own free will" and guarantees the right of all couples "to decide on the number of children." To this end, the Decision approves a wide range of family planning activities, among them birth spacing; the use of contraceptives; treatment for sterility; treatment of sexually transmitted diseases and AIDS; and the provision of sex education, which it envisages becoming part of the educational process within and outside schools. It also confirms the 1991 liberalization of abortion law by approving abortion as a means to prevent unwanted pregnancy.

In conformity with the Decision, maternity clinics and women's health centres throughout Albania will offer family planning services, and pharmacies will make contraceptives available. Officials say the hope is not only to improve maternal and child health, but to bring down the country's population growth rate, which, at 2.1 per cent per year, is the highest in Europe and growing faster than the rate of economic growth.

-Reed Boland

Cambodia's Women:

Shouldering the Burden

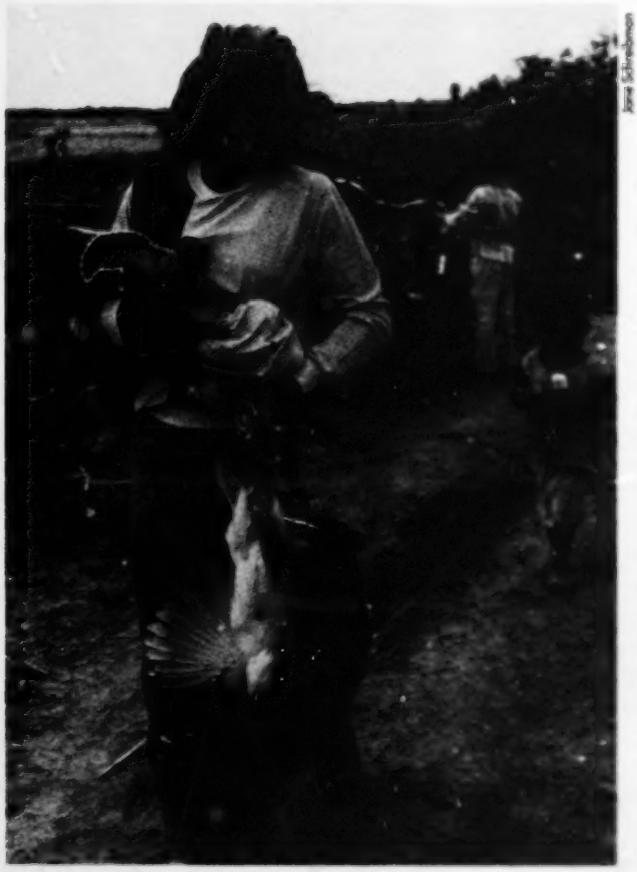
by Pat Orvis

As long-suffering Cambodia struggles to rescue peace and stability from two decades of war and civil strife, the country's social fabric is being held together by its women.

Although few statistics survived the chaos of the last 20 years, there are thought to be some eight million Cambodians. Women are thought to make up two-thirds of the adult population and the majority of the workforce—and an overwhelming majority of the country's manual and unskilled labourers. Many thousands of them are young war widows with an average of six children in a country where, some say, probably the majority of families are headed by women. In the countryside, women may receive food from neighbours and relatives. Those who move to the cities generally lack such support; on the contrary, they often take on the responsibility for supporting relatives in rural areas. Most work two jobs and seem forever to be seeking new opportunities to make ends meet.

Their situation is tenuous. The fulfilment of their basic needs, their hopes for peace, and their aspiration to a just position in Cambodian society and polity are tied to elections to be held by the end of May. As the threads of the patchwork political process unravel and are gathered again, it is especially unclear what the future holds for Cambodia's women. They continue to make sacrifices for family and community. But their demands for basic services—housing, health care, family planning—grow as the tough job of survival is made more difficult by the influx of refugees returning to a country where much of the land, sown with explosives, cannot support humans, livestock, or crops.

Cambodia has endured decades of unremitting violence. In the early 1970s, it was sucked into the desperately out-of-control war in neighbouring Viet Nam when its eastern provinces suffered intense bombing by American forces. The foreign war ended in 1975, leaving in its wake the Khmer Rouge, Maoist guerrillas led by Pol Pot, whose four-year rule is commonly referred to as genocidal.



Jane Schreiber

In charge: Women are said to head most families.

> ***"Nobody knows what the real situation is for any one population: women, children, the elderly."***

When civilian casualties abated with Vietnamese occupation in 1979, "some kind of spontaneous baby boom" occurred, in the words of Anne Bruzelius, United Nations Children's Fund (UNICEF) representative. But civil war and sanctions that prevented all but humanitarian aid to the beleaguered country spurred the departure of Cambodians in search of refuge.

Years of negotiation under the auspices of innumerable re-

Pat Orvis is a freelance print and broadcast journalist. She recently visited Cambodia and Thailand.

gional and international fora culminated in the 1991 signing of peace accords in Paris. The accords paved the way for the UN's US$2-billion peacekeeping-cum-elections operation conducted by UNTAC, the UN Transitional Authority in Cambodia. Before the accords, international aid efforts were kept alive mainly by non-governmental organizations (NGOs), including the International Committee of the Red Cross, Oxfam, and the Quakers, with some relief-oriented work by agencies such as UNICEF, the World Food Programme, and the UN High Commissioner for Refugees (UNHCR). The peace accords opened the door to development programming, which now awaits the formation of a national government to succeed the transitional Supreme National Council presided over by Prince Norodom Sihanouk.

The accords and UNTAC's presence have also seen the repatriation of Cambodian refugees. On 30 March 1992, when the first of the displaced began returning under a joint UNHCR-UNTAC programme, there were 370,000 Cambodian exiles living in Thailand, Indonesia and Malaysia, 330,000 of them in camps just inside neighbouring Thailand. Roughly two-thirds have been repatriated, allowing several camps to be closed, with return of the rest expected in time for the elections.

About 4.4 million voters—more than 90 per cent of those eligible—have been registered. Some 20 parties are expected to compete for legislative seats. Between them, they hold power over the future of Cambodia and its women, including Sichan.

With a possible 10 million land mines waiting to explode or be defused, land is scarce.

Sichan's story

Thirty-six-year-old Sichan is one of the thousands of widows left behind to shoulder most of the burden of a country starting over. She tells her experience of the years from 1975 to 1979, when the Khmer Rouge emptied the cities and towns, sending entire populations—particularly the educated—into the countryside to till the land. Many went to hastily constructed "new villages" without food, tools, or medical care. Of those who survived the conditions, many ended up in mass executions.

In 1975, a 19-year-old Sichan had to leave Phnom Penh, the capital, with her parents to work in the jungles of Kompong Cham Province, bordering Viet Nam. She worked from dawn into the night, digging canals and growing rice. She places blame squarely where she feels it

Jane Schneidman

Unmet demand for housing: Roadside dwellers.

belongs, as though every execution and every act of torture had been carried out by Pol Pot's own hand.

"The people did nothing wrong, but Pol Pot killed them. His only purpose was to kill the people," she says. "Pol Pot killed my parents. He killed my brother, and separated me from my other brothers and sister. He killed whole families, or sometimes just the father, for no reason. He forced me to live on gruel. I had little sleep. I cried all the time. I grew thinner and thinner. I got malaria and nearly died, but an old man took care of me."

In 1978, a year before the Khmer Rouge ordeal ended, when Sichan was 22 years old, she was forced to marry. She was "lucky" to be matched with a doctor, but there was "no marriage ceremony." Then her husband was ordered killed. She was left with a baby boy.

She had no clothes and no food except for the big pot of water cooked with one glass of rice and shared by many. By 1979, although civil war, hunger and disease continued, the killing and torture were mainly between armies, leaving only loneliness and the desperation to provide for her child.

By 1982, Sichan had managed to move back to Phnom Penh,

"The psychological impact of war must be dealt with."

where she got a job at the ministry of agriculture. She worked at the ministry 7:00-11:00 a.m. and 2:00-5:00 p.m., then sold cigarettes and fruit in the market until 3:00 a.m.—and again grew thinner and thinner. She studied English, sometimes taking classes at 5:30 a.m., other times on her own during the long midday breaks.

Sichan tries to help her sister, who has six children and wants to return to Phnom Penh from another province, and to help a friend, also a widow, who was beaten senseless repeatedly in the work camps. Now, that friend is forgetful. It's hard for her to answer questions, and sometimes she "acts silly."

Since last August, Sichan has had a new night job, in the office at one of the hotels which have sprung up in part to house UNTAC's 20,000-odd military and civilian peacekeepers. She has a free hour after her day job at the ministry, and "only" works from 6:00 p.m. to 11:00 p.m. at the hotel, where she earns the equivalent of US$40 a month, compared to the $15 a month she makes at the ministry.

Now she worries about her son. "I teach him English," she says. "I want him to go to college. I want him to be better than I." And she worries about Pol Pot, who now heads the Party of Democratic Kampuchea, one of four factions in the Supreme National Council.

Sichan doesn't remarry, she says, because "I am too old," and because men "look for women with money and a house of their own." She explains: "the men are afraid to be poor. Under Pol Pot, the men were very, very poor." At any rate, she considers herself lucky to have only one child to care for.

Widows who remarry usually become a second or third wife—"minor wives," as they are called in a country where polygamy has become an accepted solution to a population with so many young widows. As minor wives, they are expected to continue their jobs to support whatever children they have, while also maintaining separate households.

Although Sichan's life is in most respects typical of the daily routine of Cambodian war widows, her reluctance to have more children is closer to the new thinking aid workers observe among younger Cambodian women. By tradition, says UNICEF's Bruzelius, women in Cambodia are used to having the "protection" of a man. They are "supposed" to be married, and have a man as head of the household. For their part, Cambodian men view large families as a status symbol. It's a combination that has lead to "a lot of individual tragedies, and a lot of children born out of wedlock." But now, younger women are planning to have no more than two or three children.

With a possible 10 million land mines waiting to explode or be defused, land is scarce. Given the resulting crowding, "women of 20 or 22 don't want many children to raise," says Paolo Operti, UNICEF's primary health care officer.

Many women have heard about and express interest in injectable contraceptives and the IUD, or intra-uterine device, says Sabiha Syed, UNFPA's Bangkok-based country director for Cambodia and four other countries. "They want family planning services, but at present facilities are not available to provide safe contraception to these women."

Condoms are available in the main market in Phnom Penh and through border traffic from Thailand, but are so costly that few locals can afford them. Limited quantities of contraceptive pills are also available, but these, too, are prohibitively priced. The pills "are dispensed with no instructions, and there is no way of knowing the composition of these pills and who should take them," Syed says.

The role of UNFPA in helping Cambodia's women is to assist the government in designing comprehensive maternal and child health and family planning programmes, and to supply contraceptives. According to a UNFPA fact-finding mission, Cambodian women have "very few" public health facilities or other services, and are faced with very high maternal and infant-child mortality and morbidity rates.

There's another area of need, too, according to Denise Brown, a developmental psychologist and consultant to a new health ministry subcommittee on mental health. "After a people have been savaged and pushed around for 20 years by forces beyond their

Standing down: What will "normal life" be like?

UNHCR/M. Kobayashi

The road back: Refugees returning to Cambodia.

control, mental health and the psychological impact of war must be dealt with," she says. Post-traumatic stress disorder is one of the major problems the subcommittee anticipates.

Not that what passes for normal life is necessarily less stressful. Skyrocketing land prices in Phnom Penh are pushing the poor to the city's outskirts. From these shanty towns, "women have to leave their children alone because they must go to work [in the city]. They have no place to leave them, and nobody to leave them with. They don't know whether their children are in school, whether the school is good, what sort of accidents may happen when their children are at home unsupervised. This has to create a lot of stress," says Brown.

Khemara, a new Cambodian NGO, has set up co-operative creches in at least two villages outside Phnom Penh. Mothers take turns providing space in their homes, and supplying or cooking the food. Khemara also advances loans equivalent to US$5-15, so the women from these villages can invest in small-scale consumer goods and foodstuffs in town which they then resell in their communities. The NGO is also helping its members to cultivate the land to feed their children and sell some surplus.

Such efforts are the bedrock of Cambodia's hoped-for reconstruction.

But the first task facing development policy makers and programme staff is collecting data. In Brown's words, "nobody knows what the real situation is for any one population: women, children, the elderly."

Women "want family planning services," but there are no facilities to provide safe contraception.

MANY ASPECTS OF WOMEN'S HEALTH REMAIN NEGLECTED

More than mothers

by Marge Koblinsky, Oona Campbell, & Siobán Harlow

Women's health is ill-defined. Over the past few decades, our understanding of women's health has been driven by a focus on fertility regulation. While this focus has been eminently beneficial, it has left us with a narrow understanding of women's health bounded by the ages 15 to 45 and the reproductive system. Recently, the emphasis has broadened from fertility to include maternal health, reproductive tract infections, and to a lesser extent cancers of the reproductive organs, but many aspects of women's health remain neglected.

The dominance of reproductive functioning in our comprehension of women's health becomes obvious when one looks for a definition of women's health. There are relatively few explicit statements in the literature of what is meant by women's health. Those that exist reveal a high degree of overlap with definitions of reproductive health and maternal health.

On either side of the reproductive years, huge gaps continue to exist in our understanding of women's health. Adolescence marks a time in a woman's life when improved health status and adequate growth could help buffer the future demands of such energy-intensive activities as heavy manual labour or childbearing. Studies on the nutritional status of adolescent girls are now beginning and descriptive studies of adolescent pregnancy are under way in several parts of the world. However, most health problems experienced by adolescent girls are still under-investigated. Awareness of the problems of the mature woman—the menopausal and aging woman—has also begun to grow, particularly as the populations of many countries begin to age. This awareness has not yet solidified into a research or programme agenda. Similarly, non-maternal, non-reproductive health needs during the reproductive years have received scant attention.

We need a definition of women's health that goes beyond these limitations. For example, borrowing from a 1991 article in *Vena Journal*: A woman's health is her total well-being, not determined solely by biological factors and reproduction, but also by effects of work load, nutrition, stress, war, and migration, among others.

A definition of women's health must reflect the unique dimensions of our lives: the reproductive roles (childbirth), the biological reality (menstrual cycles), and the social context in which we live, work, and age. Each dimension impinges on our health and is in turn affected by it.

Maternal health: What's the problem?

Thanks in part to the Safe Motherhood Initiative, we are frequently reminded that 500,000 women die each year in childbirth, 99 per cent of them in developing countries. What is not so well-appreciated is that millions of women suffer illnesses and long-term disabilities related to their pregnancy. Based on the findings of a 1980 study in rural India, it is sometimes stated that for every maternal death, there are 16.5 illnesses resulting from childbirth, yielding 8.25 million maternal morbidities each year worldwide. But a review of the literature suggests this is a gross underestimate: There are over 100 cases of acute illness for every maternal death—an estimated 62 million women suffer maternal morbidities, or illnesses, annually. Few studies, if any, report the full spectrum of maternal health problems, however. Only acute morbidities—those occurring during pregnancy, delivery or in the postpartum period—are reported.

On either side of the reproductive years, huge gaps continue to exist in our understanding of women's health.

Moreover, maternal morbidity includes chronic problems such as uterine prolapse, or the downward displacement of the uterus, which become obvious only some time after childbirth. Outside hospitals, mild and moderate cases typically go unreported, as women are most likely to report prolapse only when it is severe enough for the cervix or uterus to actually protrude from the vagina. World Health Organization (WHO) investigators found women's reports of prolapse to be far lower than those detected in medical exams. Data on such conditions are scarce, however, and there are significant

Marge Koblinsky is the director of the MotherCare Project with John Snow, Inc.. Oona Campbell, of the London School of Hygiene and Tropical Medicine, is a reproductive epidemiologist with a background in demography. Siobán Harlow, a reproductive epidemiologist specializing in the menstrual cycle and occupational health, is on the faculty of the Escuala de Salud Pública de México. Together, they wrote "Mother and More: A Broader Perspective on Women's Health," a chapter in The Health of Women: A Global Perspective, *Westview Press in association with the US-based National Council for International Health, December 1992. This article was adapted from that chapter with permission from Westview Press.*

Richard Mock

Women are more than baskets of eggs.

variations in findings because of differences in defining and conducting research. Conclusions are difficult to draw.

The safe motherhood rubric focuses attention on the problems women face during pregnancy, such as hypertension and anaemia. Yet even here, we do not know all we should. Often, the prevalence of conditions is not gauged until cases become acute. Yet, there are various definitions of "acute." Anaemia, for example, causes weakness, fatigue, and leads to lowered work output but is not life-threatening in pregnant women. When severe, however, even a small loss of blood can cause death. At their best, available data provide a picture of the percentage of pregnant women suffering one specific problem. But what is the total number of women who suffer any acute problem during pregnancy?

Problems encountered during labour and delivery are typically thought to present the greatest risk for women and their infants. But because research is broken down by each of a range of complications, we have only a fragmented picture of the overall problem. Again, reports of the proportion of women suffering any complication during this period vary widely.

Having passed safely through pregnancy and delivery, women remain at risk and, in fact, are at greatest risk of death from postpartum morbidities. Identifying and managing these morbidities is especially problematic as this is the time when they are least likely to retain contact with service providers, especially if the problem emerges some time after delivery.

Unfortunately, none of the population-based studies state the percentage of total pregnant women who suffer any problem during the 46 weeks encompassing pregnancy, labour and delivery, and the puerperium, or period of confinement after childbirth. Extrapolating from various studies, it seems plausible that approximately 40 per cent of women may suffer an acute problem in the process of bearing a child. Even without taking into account many underlying morbidities, such as tuberculosis, which may be aggravated by pregnancy, or chronic conditions emerging after the puerperium, this is equivalent to some 61.8 million pregnant women with acute complications each year—and up to 23 million women needing higher-level care for severe complications!

Given the magnitude of the problem, why haven't maternal health problems been well-studied? Women's health has been neglected in general, a neglect fuelled by and fuelling a lack of information. As attention turns to maternal health, the need to develop programmes to prevent the appalling number of maternal deaths, together with a widespread assumption that the fundamentals of disease in women are already known, means that relatively low priority is given to basic epidemiological and methodological research in this area.

The menstrual cycle: Fundamental factor

Whereas maternal health is at the centre of our understanding of women's health, the public health agenda for research on women has scarcely been influenced by the fact that menstrual-cycle patterns may be a fundamental determinant of women's health status, and that alterations in menstrual function may influence many disease processes.

A 1991 article in *The Lancet*, confirming previous findings that timing of surgery during the menstrual cycle strongly influences how long women with breast cancer survive, provides a provocative illustration of the physiological significance of the menstrual cycle to women's health. Ten-year survival ranged from 84 per cent to 54 per cent depending on when in the menstrual cycle the breast cancer surgery was performed.

Despite the medical implications of women's cyclic physiology, scientific inquiry into the menstrual cycle has been limited and disjointed. Recognizing the relevance of menstrual function to women's health is not the same as assuming that women are totally defined by their reproductive hormones, however. Medical science has been too willing to accept that certain diseases—for example, premenstrual syndrome— are wholly caused by hormonal imbalances. Nonetheless, continued failure to perceive and investigate the linkages between the reproductive system and other aspects of women's health carries a great cost. In the case of timing of surgery for breast cancer, this cost may have been premature death for an untold number of women.

Whether in its presence or its absence, periodic bleeding is an integral part of a woman's life experience throughout much of her reproductive life. In addition to concern provoked by unexplained alterations in bleeding patterns, considerable illness is directly attributable to menstrual disturbances. In the United States, for example, four million visits to the doctor's office—20 per cent of all visits for problems of the female genital tract—are made each year for men-

Ron Giling

Traditional occupations such as farming must be counted as work.

strual disorders. Menstrual dysfunction and other abnormal vaginal bleeding are also the primary diagnoses for 350,000 hospitalizations per year, and dysfunctional uterine bleeding is one of the three leading reasons for hysterectomy. In a 1985 study in Niue in the South Pacific, 50 per cent of all women older than 20 reported a history of excessive menstrual pain.

Despite the magnitude of clinical problems associated with menstruation, neither the nature of variability in normal menstrual function nor the causes of menstrual dysfunction are well understood. Although the distribution of menstrual-cycle lengths within the population of women and the gross changes which occur in the population from menarche to menopause have been described, we have virtually no quantitative data on how cycle length varies from cycle to cycle within a woman as she ages or on how age-related changes may differ from woman to woman. Knowledge of why menstrual cycles vary is even more sparse.

We need to know how work affects health, and how health affects work.

To date, information is largely confined to data on the effect of weight, physical activity and stress on menstrual-cycle length, ovulation, and ovarian secretions, although our understanding of these factors also remains inadequate. Studies of weight, for example, have generally examined highly selected clinical populations or athletes, although some data exist from cultures which experience extreme seasonality in food availability.

Although some data exist about the probable impact of diet, drugs, pesticides, solvents, occupational strain, chronic stress, sound, light, social violence, and the presence of female or male companions, few epidemiological studies have been undertaken, so prevalence rates, for example, cannot even be guessed at. Furthermore, previous research has generally focused on how these factors interfere with ovulation. Focusing on ovulation and pregnancy defines the relation between menstruation and women's health too narrowly. As far as the larger impact of menstrual function on women's health, evidence continues to accumulate suggesting that a woman's internal hormonal environment plays a critical role in determining her long-term risk of developing chronic diseases such as osteoporosis, cancer, and possible cardiovascular disease.

No systematic investigation of the effect of the menstrual cycle on immune response has ever been undertaken and many studies which examine immune parameters suffer from such serious methodological flaws that they actually provide false information. Consequently, we have few clues about the optimal internal hormonal environment for promoting women's long-term health. Evaluation of the health consequences of steroid contraception and oestrogen-replacement therapy will ultimately depend upon gaining a better understanding of the complex relationship between menstrual function and women's health.

Women's work: Neglected

Only limited quantitative information is available on how women's work influences their health, despite the growing sociological and economic literature describing the number of hours spent doing household chores and the limited opportunity to rest; women's double burden of domestic duties plus economically productive work; the undercounting of women's contribution to agricultural production; and the growing importance of employment in assembly-type production in export-processing zones.

Occupation has been viewed predominantly as an indicator or determinant of socio-economic status. But we need to start considering how specific occupational characteristics—length of working day, level of physical exertion, and exposure to pesticides and other chemicals, for example—directly determine disease risk.

Three important themes emerge from preliminary studies along these lines in settings as diverse as Pakistani farming communities, low-income neighbourhoods in Brazil and India, and export-processing zones in various countries They can serve as a guide in developing an agenda for research and programme development in the area of occupation and women's health.

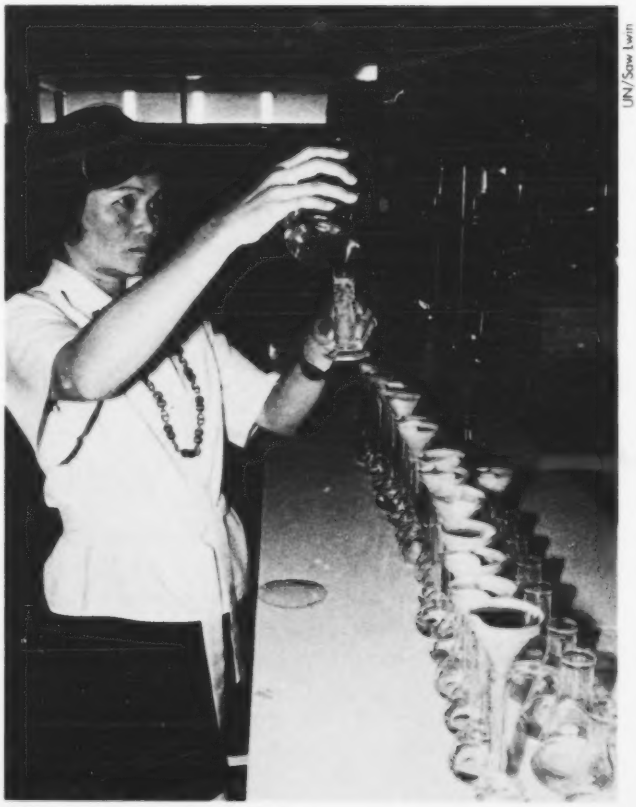
First, focus should be placed upon those occupations of predominant importance to women, including paid and unpaid domestic labour, agricultural labour, market activities, and the export-processing industry. Second, considerable effort will also be needed in identifying the specific things about each occupation that increase disease risk. Activities which demand considerable physical exertion and contribute to long-term fatigue may be particularly important, and signs of physical and mental strain may be their most relevant impact. Finally, research must explicitly incorporate women's unpaid housework in the definition and measurement of women's work activities. Similarly, traditional occupations such as farming must also be explicitly defined as work. Given the importance of the informal economy, and therefore of informal jobs, consideration should also be given to recognizing and measuring these activities.

Further attention to the specific characteristics of women's work lives may substantially enhance our understanding of the nature of women's health complaints and of the distribution of disease in female populations.

Ambitious recommendations

Women die prematurely from several causes—many causes that also kill men. One cause that is gender-specific, however, is childbirth. Haemorrhage, infection, obstructed labour, hypertensive disorders of pregnancy, and complications of induced abortion are recognized as the major killers of women during pregnancy, labour and delivery, and the postpartum period. These same problems cause serious suffering in other women as well, but may not kill them. That approximately 62 million women are estimated to experience these and other serious morbidities, or illnesses, associated with childbirth yearly suggests that considerable efforts are needed to establish how common morbidities are in pregnancy. It is also imperative to recognize that there are other conditions, including indirect maternal morbidities (where pregnancy aggravates underlying illnesses) and

The Safe Motherhood Initiative focuses attention on the problems women face during pregnancy. Yet even here, we do not know all we should.



UN/Saw Lwin

Who sets the research agenda?

UNFPA/Lily Solmssen

Asking and answering: Do they understand each other?

Policy makers, funders, and researchers must change their attitudes. This would be a first step towards a long-overdue programme that enhances women's health and quality of life.

long-term effects of pregnancy, about which little is known. A systematic listing of health problems known or thought to be associated with pregnancy and childbirth would provide an initial starting point to developing an epidemiological understanding of maternal morbidity.

Before the levels and causes of either acute or chronic maternal health problems can be determined, however, formidable methodological obstacles must be overcome. These include listing the relevant morbidities, defining them, conducting valid field measurements, and obtaining representative, population-based estimates. Two common problems in data-gathering must be overcome: locating pregnant women in situations where they do not use health services, and defining problems in ways that can be understood by interviewers and the women they interview. As research into female morbidities is still in the early stages of development, publication of results should be careful to present data that can be compared with other studies.

We also need to start understanding the effects of menstrual health and conducting population-based studies of the natural variability in menstrual cycles across the reproductive life course. This includes looking at cycle length, bleeding duration, hormonal patterns, and metabolic pathways. Once these patterns are established, epidemiological studies are needed to identify their direct and indirect causes. Basic research on the effect of hormones and variability in hormonal levels across the menstrual cycle on women's physiology is also needed, as are systematic research programmes on the relationship between the internal hormonal environment and chronic disease. Finally, as with maternal morbidity, we need a research methodology for studying menstruation that is suitable for field use, and analytic methods for evaluating hormonal patterns and menstrual diary data.

The contribution of a woman's biology (as exemplified by her reproductive role and her menstrual function) to her health is not the only component in gender-specific health problems. Consideration must also be given to how women's social roles impinge on their health. These are often complex issues to research. With women's work, for example, consideration must be given not just to how work affects health, but also to how health affects work. The interaction of activity and health can also be seen in aging women, where part of the phenomenon of successful aging depends on purposeful activity. The specific characteristics of women's lives as they work and age may substantially enhance our understanding of the nature of women's health complaints and of the distribution of disease in female populations.

Achieving these ambitious recommendations necessary to understand female morbidities will involve work in conceptualizing and researching the problems. Perhaps more importantly, however, it involves an attitudinal change on the part of policy makers, funders, and researchers to allow for a broader definition of women's health which incorporates the full length of our lives, the full range of our activities, and all the discomforts and illnesses we face. This would be a first step towards a programme that enhances women's health and quality of life—a programme long overdue.

Women's Health

For all the rhetoric about women and development, we know precious little about women's health. In the absence of a women-centred health research agenda encompassing clinical, social, and epidemiological approaches and covering women's entire life span, preventive and curative health care programmes are based on assumptions, and therefore often fail to meet women's true needs. These are among the assertions of the contributors to *The Health of Women: A Global Perspective*, published by Westview Press in association with the United States-based National Council for International Health (NCIH). The chapters, by leading researchers in their fields, range from the blows dealt to women's health by the debt crisis and women's exclusion from power structures and systems; research and programming problems; and physiological and psychological conditions encountered by women; to possible ways of creating more acceptable and effective services. The book is the product of the 1991 NCIH conference, "Women's Health: The Action Agenda." Priced at US$49.95 (hardback)/ US$16.95 (paper). To order, contact: Westview Press, Customer Service Department, 5500 Central Avenue, Boulder, CO 80301-2877, USA. Telephone: (303) 444-3541. Fax: (303) 449-3356.

Ghana Bibliography

Women in Ghana: An Annotated Bibliography includes 754 citations to monographs, books, periodicals, conference papers, government and project reports, and theses. Materials were reviewed from libraries and repositories throughout the West African country, and include items published from the early twentieth century through 1988. Publications from Britain, Europe, and the United States are also included selectively. Major sections deal with women and development, population, agriculture and environment, education, health, labour, law and politics, and culture and religion. By Elizabeth Ardayfio-Schandorf and Kate O. Kwafo-Akoto; published by Waeli Publishing Services, Accra. Awarded Honourable Mention by the African Studies Association (USA) book prize. Publication supported by UNFPA. For more information, contact: UNFPA, 7 Ring Road East, P.O. Box 1423, Accra, Ghana.

Fertility Patterns

Fertility levels in many industrialized countries fell to such low levels between the mid-1960s and early 1980s, that governments "became increasingly preoccupied with the social consequences of such a trend, notably the need to meet labour force requirements and the social cost of an ever-increasing aging population," according to the authors of *Patterns of Fertility in Low-fertility Settings*, a study from the United Nations Population Division. The study "appraises the magnitude of the fertility decline in terms of levels and trends between 1965 and 1988 in a number of countries where fertility is currently very low." For more information, contact: Director, Population Division, Department of Economic and Social Development, United Nations, New York, NY 10017, USA.

Choice Slide Show

The Role of Informed Choice in Family Planning is a slide show prepared for family planning policy-makers, programme managers, and workers by Johns Hopkins University. The 20-minute show consisting of 68 slides is based on research showing that when people choose a contraceptive method and it is properly explained to them, they are more likely to use it correctly and continue to practise family planning in the long run. The slides are available free of charge in developing countries, and may be ordered from: The Johns Hopkins University, Center for Communication Programs, 527 St. Paul Place, Baltimore, MD 21202, USA.

Family Newsletter

The Family is the official bulletin of the International Year of the Family (IYF), 1994. The Year's motto is "Building the smallest democracy at the heart of society." Published by, and available from: IYF Secretariat, P.O. Box 500, A-1400, Vienna, Austria.

Women, Institutions, Management

The Centre for Development and Population Activities is offering training workshops for managers and administrators from development organizations. "Women in Management: Leadership Training for the '90s" is scheduled for 17 May-18 June. "Institution Building: Strategic Management for the '90s" will be held in French on 19 July-20 August, and in English on 20 September-22 October. The Centre was founded in 1975. Its mission is to "empower women at all levels of society to be full partners in development," according to a press release. For more information, contact: Workshop Associate, CEDPA, 1717 Massachusetts Avenue, Suite 200, Washington, D.C. 20036. Telephone: (202) 667-1142. Fax: (202) 332-4496.

Policy Research Courses

The Population Policy and Research Program of the University of Southern California Department of Sociology's Population Research Laboratory is offering these courses: methods of population and ecological analysis and population trends, public and private policies, 12 May-29 June; and computer applications to sociology and other social sciences and fertility control policies, 30 June-17 August. For more information, contact:

Maurice D. Van Arsdol, Jr., University of Southern California, Department of Sociology, Population Research Laboratory, 3716 South Hope Street, Room 385, Los Angeles, CA 90007-4377, USA. Telephone: (213) 743-2950. Fax: (213) 743-7408. Telex: 674803.

Training Fellowships

The Population Research Laboratory at the University of Southern California's Department of Sociology is announcing predoctoral traineeships in population studies funded by the William and Flora Hewlett Foundation, the Fred H. Bixby Foundation, and the Hugo R. Santora Endowed Fellowship Fund in Memory of Jene F. Foote. The fellowships are available as of 1 May and 1 September 1993. Awards funded by the Hewlett Foundation and the Santora Fellowship are limited to students from developing countries. Trainees are enrolled in population studies programmes in social science departments or in the Schools of Gerontology and Public Administration. Letters of inquiry should be accompanied by vitae and three letters of recommendation, and should be addressed to: Maurice D. Van Arsdol, Jr., Population Research Laboratory, 3716 South Hope Street, Room 385, Los Angeles, CA 90007-4377, USA. Telephone: (213) 743-2950. Fax: (213) 743-7408.

Lectures

There are four titles in the Family Planning Foundation of India's "Encounter With Population Crisis" series. Each is based on lectures delivered under the Foundation's auspices. They are: *Population: A Challenge to Contemporary Development Strategies*, by Norman Borlaug, who is known as the founder of the Green Revolution; *Population and Environment: How to Meet the Twin Challenge in India*, by M. S. Swaminathan, recipient of the first World Food Prize; *Population, Poverty, and Environments*, by industrialist and United Nations Population Award recipient J.R.D. Tata; and *Population Stabilization Strategies in India: An Assessment*, by Asok Mitra, a former Registrar General of India and member of the UN Population Commission. For more information, contact: Family Planning Foundation, B-28 Qutab Institutional Area, Tara Crescent, New Delhi 110016, India. Fax: (91-11) 685-2766.

Safe Motherhood

Reports, fact sheets, and audio-visual materials from the Safe Motherhood Initiative are available from Family Care International, a New York-based non-governmental organization founded in 1987, the year the Initiative was launched. Recent titles include: *Vital Allies: Making Motherhood Safe for the World's Women*, a video providing a global overview of maternal mortality and morbidity and examining effective Safe Motherhood projects; *Your Health, Your Pregnancy: A Guide for the African Woman*, a book written in non-technical language; and *Acting to Save Women's Lives*, the final report of the March 1992 meeting of the Partners for Safe Motherhood. Fact sheets are available for West Africa, Southern and Lusophone Africa, South Asia, Central America, Mexico, and the world. For more information, including a catalogue of available products, contact: Family Care International, 588 Broadway, Suite 503, New York, NY 10012, USA. Telephone: (212) 941-5300. Fax: (212) 941-5563. Most products are available at concessional rates to individuals and organizations in developing countries.

Women Speak

Power, Population and the Environment: Women Speak is a trilingual compilation of essays by women written in advance of the June 1992 Earth Summit in Rio de Janeiro. Compiled by Gillian Phillips, director of the Ottawa-based Sexuality Information and Resources Clearing House for the Women and Environments Education and Development Foundation, the essays are presented in English, French, and Spanish. For more information, contact: WEED Foundation, 736 Bathurst Street, Toronto, Ontario M5S 2R4, Canada.

Worms

"I have walked a long path of health promotion from parasite control to preventive health services, family planning and international co-operation for the Integrated Family Planning and Parasite Control Project," writes Chojiro Kunii, in *It All Started from Worms: The 45-Year Record of Japan's Post-World War II National Health and Family Planning Movement*. The book contains photographs, poems, and personal recollections by Kunii, now chair and executive director of the Japanese Organization for International Co-operation in Family Planning. For more information, contact: JOICFP, Hoken Kaikan Bekkan, 1-1, Sadohara-Cho, Ichigaya, Shinjuku-Ku, Tokyo 162, Japan.

Conference Newsletter

ICPD 94, formerly *Population 94* is the official newsletter of the 1994 International Conference on Population and Development. Published every two months in English, French, and Spanish, it sets out to update readers on preparations for the decennial conference scheduled for September 1994 in Cairo, Egypt. For more information, contact: ICPD 94, ICPD Secretariat, c/o UNFPA, 220 East 42nd Street, 17th floor, New York, NY 10017, USA. Telephone: (212) 297-5222/5230/5244. Fax: (212) 297-4915. Telex: 7607883.

	Male Sterilization	Female Sterilization
Description:	Vasectomy: excision of the duct transporting sperm to the penis. Minor outpatient surgery done under local anaesthesia; can be performed with or without a scalpel.	Tubal ligation: blocking the fallopian tube, which leads to the uterus. Tubectomy: excision of a portion of the uterine tube. Can be done on outpatient basis under local anaesthesia; requires medical backup facilities and special equipment.
Resupply requirement:	None	None
Lowest expected failure rate during the first year:	0.1 per cent	0.2 per cent
Typical failure rate during the first year:	0.15 per cent	0.4 per cent
Effect on risk of infection with sexually transmitted diseases:	None	None
Appropriate for breastfeeding women?	Yes (male method; no effect on woman)	Yes
Return to fertility?	Permanent method; surgical reversal requires general anaesthesia, takes an hour or two, and is expensive; chances of success are limited.	Permanent method; as with male sterilization reversal, complex and expensive surgery under general anaesthesia is required, and the chances of success are limited.
Side effects/Complications:	Some men report minor swelling, pain, infection, and bruising following procedure. Risk of serious complications or death extremely low.	Some women report pain and bleeding and wound infection following procedure. Possible complications include injury to other organs and, rarely, death; increased risk of complications if general anaesthesia is used.

DICTIONARY

Family Planning

Practices which help individuals or couples to avoid unwanted births, to bring about wanted births, and to determine the number of children in a family.

Unwanted pregnancies are avoided by contraception. "Modern" methods include barrier (condoms, diaphragms), hormonal (pills, implants, injectables), and surgical (vasectomy, female sterilization) contraceptives. "Traditional" or "natural" methods include periodic abstinence or the "rhythm method," and withdrawal or *coitus interruptus*.

(**Source**: United Nations Population Fund, "Guidelines for UNFPA Support to Family Planning Programmes," December 1992.)

Sources:

- World Health Organization, *Contraceptive Method Mix: Guidelines for Policy and Service Delivery*, as reported in: Program for Appropriate Technology in Health (PATH), "Contraceptive Method Mix: The Importance of Ensuring Client Choice," in *Outlook* Vol.10, No.1, May 1992.
- *Dorland's Pocket Medical Dictionary*, 23rd Edition, W.B. Saunders Co., 1982.
- Association for Voluntary Surgical Contraception and UNFPA statements as reported in POPULI and *Population*.

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93/20003/E/9500 ISSN 0251-6861